Correspondence

The Editors will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words and must be typewritten, double-spaced, and submitted in duplicate (the original typescript and one copy). Authors will be given the opportunity to review the editing of their correspondence before publication.

Nervous About Ticks—Assessing Lyme Disease Risk in San Diego County

To THE EDITOR: The recent finding of a tick infected with the Lyme spirochete in Orange County near the San Diego County border has stimulated public interest and occasional hysteria (J. Webb, PhD, Orange County Vector Control District, oral communication, June 1991). To assess the probability of acquiring Lyme borreliosis in San Diego County, in November 1990 we began screening those areas reportedly high in tick numbers or anecdotally associated with case reports of Lyme borreliosis. Tick sampling for questing adults was done by dragging or flagging.[1]* Habitat with appropriate vegetation and animal reservoirs was emphasized. Sites yielding high numbers were revisited about once a month during the cool season. Adult specimens of the Western black-legged tick, *Ixodes pacificus,* a known competent vector of *Borrelia burgdorferi,* were readily obtained (n = 1,046). These often locally outnumbered the cumulative tally of other tick species present, including the Pacific Coast tick and the American dog tick (*Dermacentor occidentalis* and *Dermacentor variabilis*). We individually dissected 250 adult *I pacificus* (both sexes) from nine identified collection sites around the county for midgut darkfield examination and direct immunofluorescence staining (method verified with R. S. Lane, PhD, Department of Entomological Sciences, University of California, Berkeley, oral communication, March 1991. Monoclonal antibody was obtained from A. G. Barbour, MD, PhD, University of Texas Health Science Center at San Antonio, written communication, February 1991. Tick specimens were verified by R. E. Monroe, PhD, College of Sciences, San Diego State University, as consistent with *I pacificus* Cooley and Kohls, oral communication, June 1991). Among these we found none infected with *B burgdorferi.* From this work we can infer, with $\alpha = .05$ and 90% power, that the current overall San Diego County infection rate in competent tick vectors is less than 4% (one-sided test), compared with estimates of overall prevalence at sites in northern California of 1%.[1]

We conclude that a competent vector for Lyme disease is widely prevalent in San Diego County and is in some foci very numerous. With increased public penetration of wilderness areas, increased attention to a Lyme borreliosis health hazard is warranted. An ongoing program of monitoring vector and reservoir populations seems prudent considering the factors of rapid development and human encroachment on vector habitat.

*Carrie Fogarty, Nancy Scarduzio, and James D. Lang, PhD, assisted in collecting ticks. A. S. Benenson, MD, provided methodologic advice.

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REFERENCE

1. Lane RS, Lavoie PE: Lyme borreliosis in California—Acarological, clinical, and epidemiological studies. Ann NY Acad Sci 1988; 539:192-203

A Medical Practice Opinion Program

To THE EDITOR: I read with considerable interest the article in the August 1991 issue on the perils of providing medical opinion.[1]

I think there is a need for this type of program and that even though the economic risks are considerable, the program should continue. The California Medical Association ought to reactivate the Medical Practice Opinion Program and either assume the liability and economic consequences or direct that the requests for medical opinion be funneled through the Medical Board of California.

As a medical practitioner and observer of the many medical, political, and economic issues in our society, it is my opinion that if this program is not reactivated and if physicians, hospitals, and medical societies are not willing to express a reasoned and well-thought-out opinion, there will be increasing pressures to allow marginal medical and pseudo health procedures to be perpetrated upon the public. I am already observing the rise of certain marginal procedures and marginal indications for procedures that years ago never would have occurred.

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REFERENCE

1. Williams HE, Ramsey LL: The perils of providing medical opinion—A state medical association's experience. West J Med 1991 Aug; 155:183-185

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To THE EDITOR: I am writing to comment on the article entitled "The Perils of Providing Medical Opinion" in the August 1991 issue.[1] It seems to me that this is a highly worthwhile function performed by the medical association and one that should be continued at all cost. The cost of litigation cited in the article seems low in view of the public service provided and particularly in view of the size of the membership supporting this activity.

The solutions suggested certainly should be pursued, particularly those seeking immunity from prosecution through legislative action and those continuing the program at full activity, even if this requires further financial support from the membership.

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1. Williams HE, Ramsey LL: The perils of providing medical opinion—A state medical association's experience. West J Med 1991 Aug; 155:183-185

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To THE EDITOR: The article in the August 1991 issue entitled "The Perils of Providing Medical Opinion"[1] caught my eye. It was so lucid and cogent that it stimulated thought.

Under possible solutions, let me suggest either a new one or perhaps a modification of your third alternative—the one to funnel all requests through the Medical Board of California. What seems to be needed is an expression of legislative intent or perhaps legislative action that recognizes the great public health benefit of unfettered professional opinions.

Why doesn't the California Medical Association work with the physician members of the legislature to introduce legislation that would require the Medical Board and the Department of Consumer Affairs to sample expert professional opinion on issues at the growing edge of medicine. It would be the further responsibility of the Medical Board or the Department of Consumer Affairs to publish these opinions in the public interest.

A vital piece of the new legislation would be that the Department of Consumer Affairs or the Medical Board be empowered to contract with long-established, viable, and representative professional organizations to provide the technical and clinical bases for opinions.

This is, of course, the germ of an idea only, but at least it is an attempt to reactivate the Medical Practice Opinion Program and at the same time protect it from capricious or venal suits.

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REFERENCE

1. Williams HE, Ramsey LL: The perils of providing medical opinion—A state medical association's experience. West J Med 1991 Aug; 155:183-185

Mistreatment of Gay Medical Students

To THE EDITOR: I read with great interest the report by Dr Baldwin and colleagues concerning medical students' perceptions of mistreatment during their training.[1] Several areas of abuse were discussed, including humiliation, threats of physical harm, actual physical violence, and sexual, as well as racial, harassment.

There exists another form of sexual abuse, however, that was not specifically mentioned in this very well-written and thoroughly researched paper—the abuse perpetrated on gay and lesbian medical students by some members of faculty, medical staff, nursing staff, resident physicians, and peer student groups.

One type of abuse is the general and practically universal blindness of the medical profession toward the existence of gay physicians and medical students. Although many would deny their existence, gay health professionals clearly exist.[2,3] The conspiracy of silence and the unwillingness to acknowledge the presence of gays in medicine make it virtually impossible for a gay medical student to have access to gay role models. Many gay faculty and staff physicians do not feel comfortable about revealing their gayness because of potential reproach or hostility from peers or authority figures. I know this because of my own gayness.

Physicians and other health professionals have been shown to harbor very negative attitudes towards gay medical students and gay physicians.[4,5] These negative and prejudicial feelings are occasionally openly demonstrated, often in the form of a "joke," at which the gay or lesbian medical student may feel compelled to smile. Gay health professionals may be exposed to homophobic snide remarks, snickers, and derogatory comments and gestures. These I have personally encountered, a result of which I have felt hurt, anger, resentment, fear, humiliation, and embarrassment; in short, I was abused.

Most people assume the heterosexuality of physicians, and some feel compelled to force heterosexual behavior upon them. One of my teachers made a vigorous attempt to persuade me to date a certain woman physician, to my utter humiliation and confusion. I do not date women and trying to make me do so is a form of sexual abuse.

Being a gay physician, I know how much it can hurt to hear people unjustly comment on a sexuality about which they actually know little. This bigotry is clearly a form of sexual abuse. Gay and lesbian medical students need not be subjected to these painful, ignorant, and biased forms of behavior from teachers, peers, or co-workers.

I am happy and proud of my gayness. I have revealed the fact that I am a gay pediatrician through my published work.[6] I will not be silent about the pervasive sexual abuse being done to gay and lesbian members of the medical profession, including our medical students, who are particularly vulnerable to this outrage.

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REFERENCES

1. Baldwin DC Jr, Daugherty SR, Eckenfels EJ: Student perceptions of mistreatment and harassment during medical school—A survey of ten United States schools. West J Med 1991; 155:140-145

2. Wolcott DL, Sullivan G, Klein D: Longitudinal change in HIV transmission risk behavior by gay male physicians. Psychosomatics 1990; 31:159-167

3. Sharkey L: Nurses in the closet: Is nursing open and receptive to gay and lesbian nurses? Imprint 1987; 34:38-39

4. Matthews WC, Booth MW, Turner JD, Kesler L: Physicians' attitudes toward homosexuality—Survey of a California county medical society. West J Med 1986; 144:106-110

5. Wallack JJ: AIDS anxiety among health care professionals. Hosp Community Psychiatry 1989; 40:507-510

6. Fikar CR, Koslap-Petraco M: What about gay teenagers? (Correspondence). Am J Dis Child 1991; 145:252

HIV Incidence in Nevada?

To THE EDITOR: In their recent article summarizing the epidemiology of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) in Nevada, Jarvis and Semiatin state there were 737 new HIV "seroconversions" during the first 12-month period (beginning July 1988) in which laboratories were required to report positive HIV test results, with an additional 100 "seroconversions" reported each year from anonymous test sites.[1] The authors conclude that "Taken together, these statistics seem to indicate that Nevada is experiencing nearly a thousand new HIV infections each year."[1(p40)] We think the data presented are not sufficient to estimate HIV incidence.

The authors present HIV testing and seroprevalence data from laboratories, anonymous test sites, civilian applicants for military service, unlinked anonymous newborn testing, and mandatory screening of newly incarcerated prisoners. These data measure the number of HIV-infected people in each population at the time testing was done but do not indicate when HIV exposure or seroconversion occurred. Prevalent HIV infection estimates represent the sum of new infections occurring in past years minus the number of deaths and migrations out of the state. Thus, incident HIV infections in the most recent year may represent a relatively small proportion of the infections cited by the authors. In addition, seroprevalence estimates may be artificially biased upward because many unlinked seroprevalence studies and anonymous testing strategies cannot differentiate the number of unique seropositives versus the number of positive antibody tests. Finally, persons at increased risk for HIV infection may be more likely than persons at lower risk to seek publicly funded services where antibody testing may be available.

Estimating the number of new HIV infections during a